2011 Military Health System Conference

Access to Care– TRICARE Standard & Extra: The Benefit, Provider Acceptance and Beneficiary Access

Results of Ongoing Beneficiary and Provider Survey

The Quadruple Aim: Working Together, Achieving Success

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25 Jan 2010 [1615-1700 Hrs)

OASD(HA)/TMA-TPOD

Purpose of This Briefing

- Review TRICARE Standard and Extra Benefit
- Provide cumulative results of second year of 4-year survey strategy to OASD(HA) & TMA leadership.
  - Comply with legislative requirement to survey beneficiaries and civilian providers from 2008 to 2011.

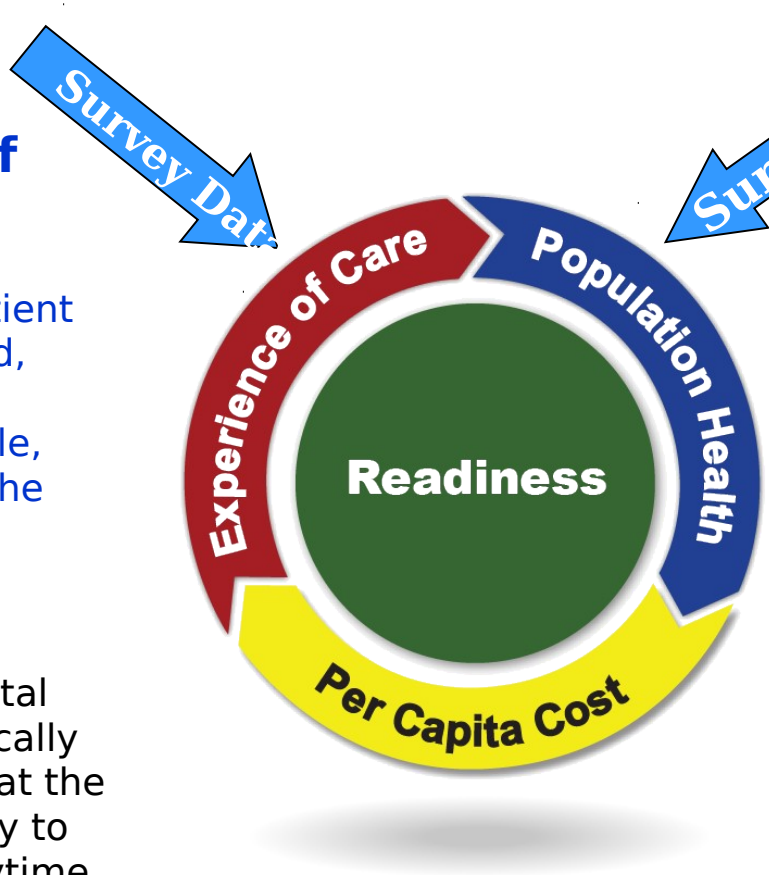
The Quadruple Aim: The MHS Value Model

Experience of Care

Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.

Readiness

Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.



Population Health

Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.

Per Capita Cost

Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

TRICARE Standard and Extra Benefit

- TRICARE options for active duty family members, retired service members and their families, survivors, certain former spouses, and others
  - **Not** eligible for TRICARE Prime based on location and/or
  - Prefer additional freedom of provider choices
- Comparison to commercial plans
  - TRICARE Standard – Indemnity plan – Most choice
  - TRICARE Extra – Preferred provider plan – Discounts

TRICARE Standard and Extra Costs

- Deductibles
  - Must be met each fiscal year before cost sharing begins
  - Vary based on beneficiary category and type of coverage (individual or family)
- Cost Shares
  - Vary by beneficiary category
  - Discounts if network (preferred) provider seen
- Catastrophic Cap
  - Vary by beneficairy category to limit out-of-pocket expenses

Relationship with Providers

- TRICARE Authorized Provider
- TRICARE Network Providers

An at will relationship exists between TRICARE Standard / Extra beneficiaries and TRICARE authorized providers

2011 Military Health System Conference

Provider & Beneficiary Surveys

The Quadruple Aim: Working Together, Achieving Success

The Quadruple Aim: The MHS Value Model

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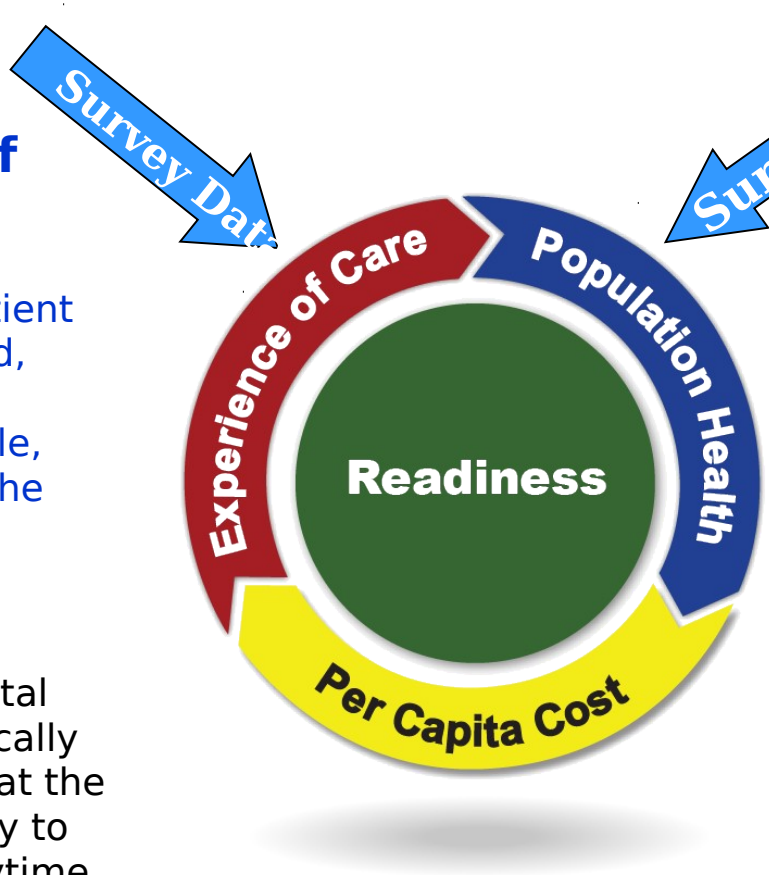

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Purpose of This Briefing

- Provide cumulative second year results of on-going four-year survey
  - Comply with legislative requirement to survey beneficiaries and civilian providers from 2008 to 2011.
- Address questions raided by legislative requirement, e.g., does civilian provider awareness and acceptance of S/E differ between PSAs and non-PSAs? By specialty?

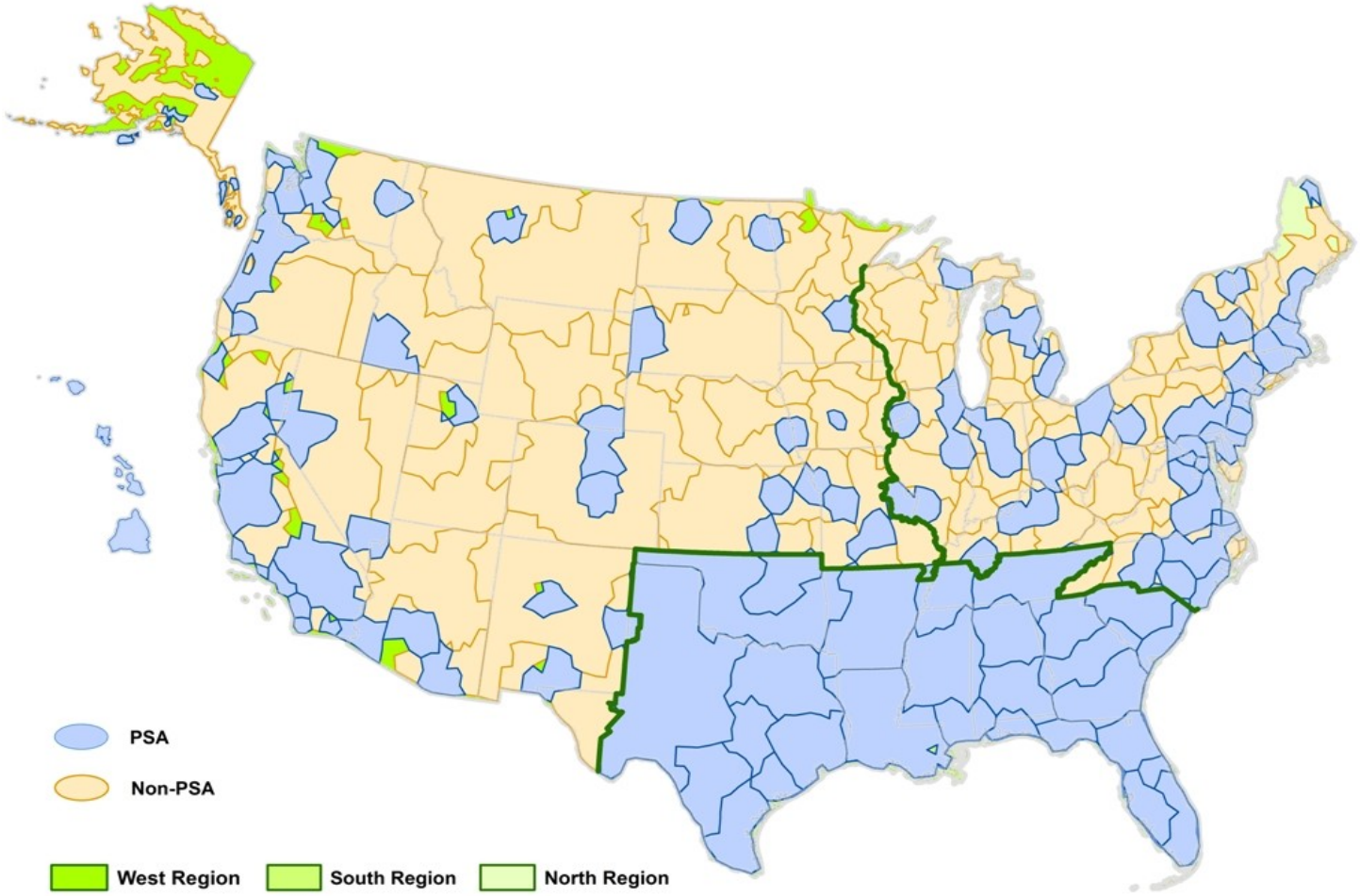
Legislative Requirements for Survey

- The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008, Section 711 (Public Law (P.L.) 110-181) requires:
  - Two surveys: one of providers and one of TRICARE beneficiaries.
    - Survey civilian providers (physicians and non-physician mental health providers) to assess acceptance of TRICARE Standard/Extra patients, in at least 20 geographic areas where TRICARE Prime is offered and 20 where it is not offered.
    - Survey beneficiaries in same locations as surveyed providers, especially where Selected Reserve members reside, to identify extent of problems of access or satisfaction.
      - Beneficiary sample includes beneficiaries eligible for Standard or Extra: active duty family members, mobilized reservist family members, retirees and TRICARE Reserve Select (TRS) enrollees.
  - Solicit input from beneficiaries (TRICARE Beneficiary Panel) and providers (representative of the American Medical Association) to identify locations where access is considered a problem and identify relevant Hospital Service Area (HSA) for survey; add TRICARE Regional HSA- level input if sample allows.
    - Government Accountability Office review of survey process, procedures and analysis, and action taken by the Department to ensure ready access to the Standard/Extra benefit.

Survey & Analytic Strategy

- Divide U.S. into 160 PSA and non-PSA areas in order to survey providers and beneficiaries in 20 PSA and 20 non-PSAs per year, for 4 years (2008-2011).
- Use TRO-defined PSAs to define 80 PSA regions (including TRO-South- sub regional areas); and divide rest of U.S. into 80 non-PSAs, by combining Dartmouth's Hospital Referral Regions (HRRs)- see map.
- Supplement each annual survey with HSA-level geographic areas as identified by the TRICARE Beneficiary Panel, AMA or TROs.
- Which will provide, at the end of four survey years, reliable estimates of access and provider acceptance at several levels: (1) national, (2) PSA/non-PSA, and (3) specified HSAs. We should be able to provide state-level estimates after post-survey adjustments to re-weight data to state-boundaries.

Survey Strategy: Prime Service Areas and Notional Survey Areas without Prime Networks (160 total: 80 each)



Although the entire South is Prime, it is still broken out into PSAs. Sub-regions are: Southeast Market - Georgia, Florida (except Panhandle), South Carolina Gulfsouth Market - Panhandle of Florida, Mississippi, Alabama, Tennessee, Eastern Louisiana Southwest Market (Former Region 6) - Oklahoma, Arkansas, Western Louisiana, Texas (except El Paso area)

2008-2010 Survey Location Methodology

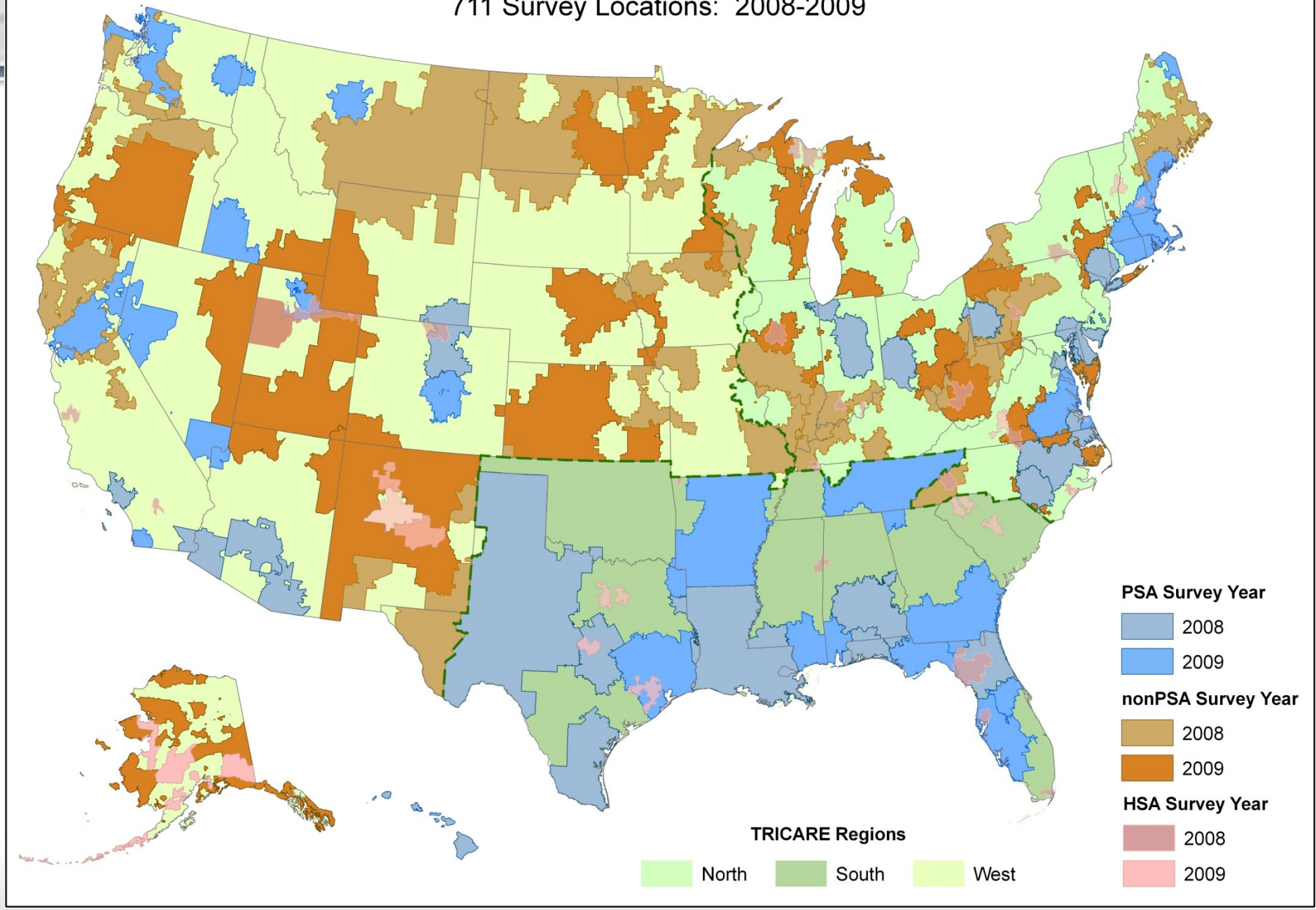
2008 and 2009 Surveys

- 40 PSAs (20 different/year)
- 40 non-PSAs (20 different/year)
- 30 different HSAs (21 in 2008 & 9 in 2009)

2010-2011 Surveys

- 20 different PSAs/ Year
- 20 different non-PSAs/Year
- 25 different HSAs in 2010; ?? In 2011

711 Survey Locations: 2008-2009



Cumulative Beneficiary Survey Findings

- Standard/Extra (S/E) users in non-PSAs:
  - **Report similar ratings to S/E users in PSAs of global satisfaction** with: "Health Plan", Personal Doctors and Specialists; and access to behavioral health providers or *receiving preventive care*.
  - **Report greater access** to *getting needed care*, and *getting care quickly* than S/E users in PSAs; **and greater access against the civilian benchmark.**
  - **Report fewer problems** *finding personal doctors, getting to see specialists, and getting timely urgent care than S/E users in PSAs.*

Comparison of Results Across Survey Years and Overall: Standard/Extra Users

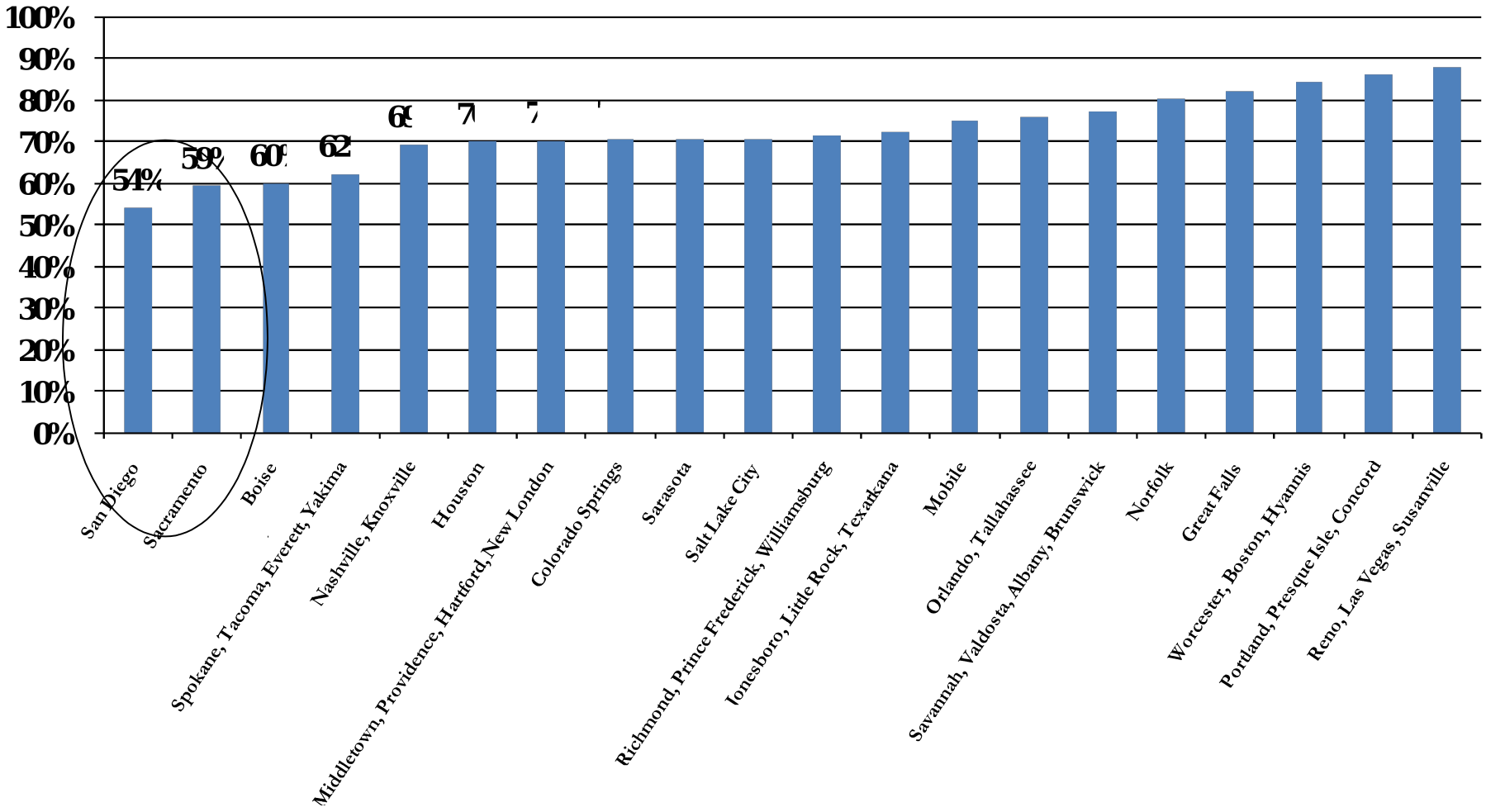
Care experiences	2009 PSA vs. non- PSA			Updated 2008 PSA vs. non- PSA			2008 & 2009 Combined			Benchmark
	All	PSA	Non-PSA	All	PSA	Non-PSA	All	PSA	Non-PSA	
Global Ratings (rating of 8+ on 0-10 Scale):										
Health Plan	66%	66%	63%	62%	61%	63%	64%	64%	63%	64%
Health Care	**80%^**	**80%^**	**82%^**	79%	78%	**82%* ^**	**80%^**	**79% ^**	**82%*^**	77%
Personal Dr.	**79%^**	**79%^**	**79%^**	78%	78%	79%^	**78%^**	**78% ^**	**79%^**	76%
Specialist Dr.	79%	79%	79%	80%	80%	79%	**79%^**	79%	79%	77%
Access:										
Getting Needed Care	80%	79%	**82%* ^**	79%	78%	81%	79%	79%	**82%*^**	79%
Getting Care Quickly #	**82%^**	81%	**86%* ^**	80%	79%	**83%* ^**	**81%^**	80%	**85%*^**	79%
Access to Personal Dr.	66%	65%	68%	65% ^	64%	67%	**65%^**	**65% ^**	68%	**68%**
Access to Specialist	74%	**73%^**	**79%***	**72% ^**	**71% ^**	76%	**73%^**	**72% ^**	**78%**	**76%**
Behavioral Health Prov	76%	76%	74%	68%	67%	73%	72%	71%	74%	na

Notes: * Green & Bold = shows higher raw percentage (PSA vs. Non-PSA)different from PSA; p<.05
^ & Bold = different from benchmark, p<.05
# Non-PSA in 2008 base survey higher, p<.05

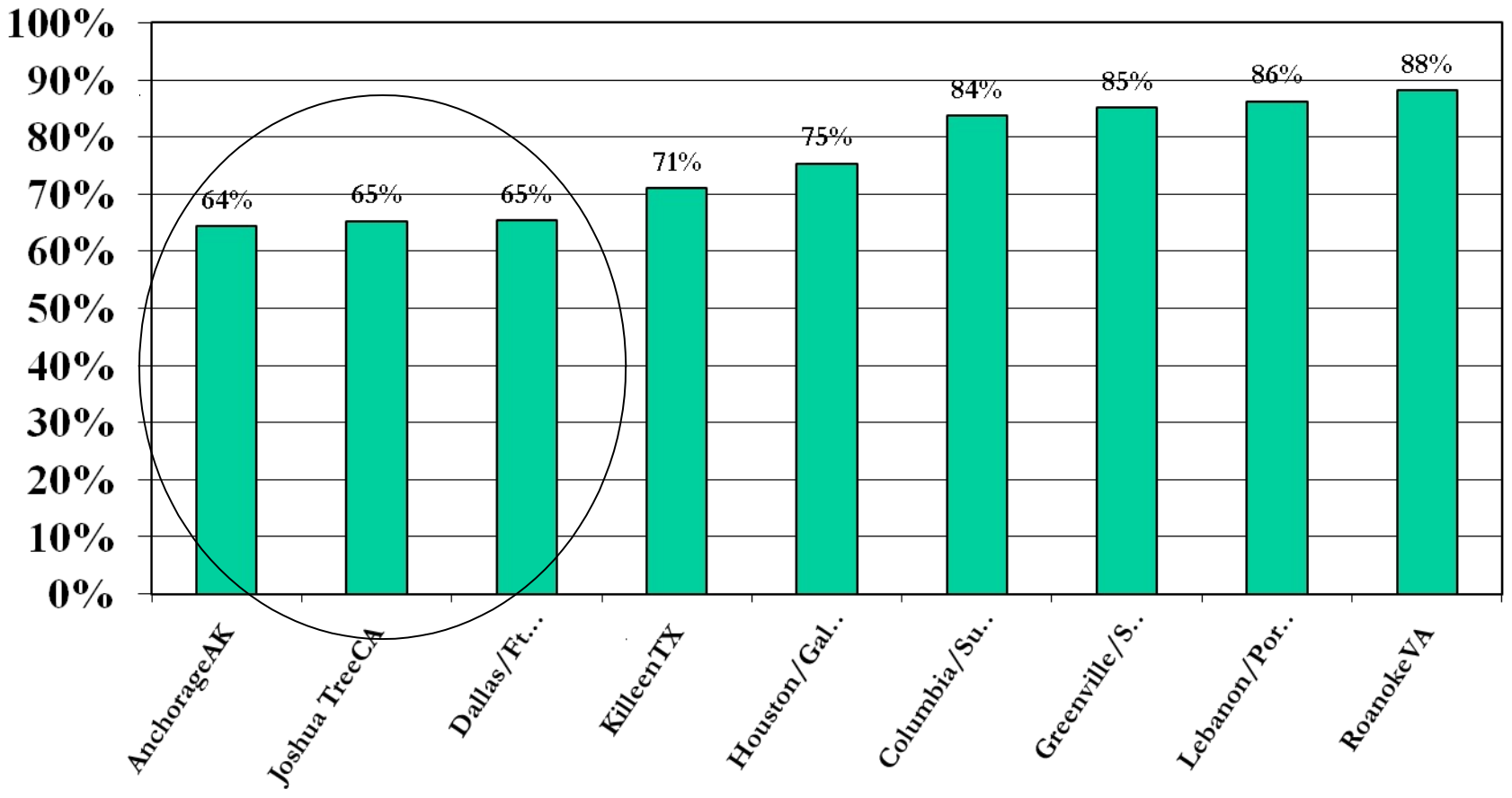
Cumulative 2008 – 2009 Beneficiary Survey Findings (Continued)

- **Variation within group**, especially PSAs, and HSAs.
  - That is, among PSAs, the range of average ratings offer locations of opportunity to improve the Standard benefit for specific aspects, such as access, preventive services, etc.

Example of Variation: Standard/Extra User Responses by PSA (2009 Sites): Getting to See a Specialist



Example of Variation: Standard/Extra User Responses, by HSA (2009 Sites): Getting Needed Care



Note - Beneficiaries in Anchorage AK, Joshua Tree CA, and Dallas/Ft Worth TX HSAs reported the lowest percentage of Getting Needed Care

Access Measures by Type of PSA and Proximity to MTFs: Standard/Extra Users, 2008 through 2010

Access in PSAs is lower than non-PSAs, for all types of PSAs (MTF, BRAC, etc.)

Region Type	Personal Doctor	Specialist	Getting Needed Care	Getting Care Quickly	Behavioral
Non-PSA	68%	79%	82%	84%	73%
MTF	65% *	74% *	79% *	80% *	72%
BRAC	63% *	72% *	78% *	78% *	71%
Other PSA**	64%	72% *	78% *	80% *	69%

Adjusted for age, health status and sex

* Significantly different from non-PSA, $p<.05$

** Includes "expanded", NCP, non-MTF PSA

Cumulative 2008 – 2009 Beneficiary Survey Findings (Continued)

- **Additional analysis**: when we split non-enrolled beneficiaries into two groups: those who relied on Standard and Extra and those non-enrollees who relied on other than Standard Extra, and compared their ratings, we find mixed results.
  - 37% (PSAs) to 43% (non-PSAs) reported using S/E during the 12 months prior to the survey (hence 63% to 57% did not, and used their own insurance).
  - S/E users, compared to MHS users relying on other health insurance and not S/E, report similar global ratings of satisfaction but mixed access and use of preventive services.

Summary of 2008/2009 Results: Comparing Std/Extra to Non-Std Averages

Care experiences	2008/2009 Std/Extra vs. Non-Std		
	All	PSA	Non-PSA
Global Ratings (rating of 8+ on 0-10 Scale):			
Health Plan	No diff	No diff	No diff
Health Care	No diff	No diff	+
Personal Dr.	No diff	No diff	+
Specialist Dr.	No diff	No diff	+
Access:			
Getting needed care	--	--	--
Access to Personal Dr.	--	--	No diff
Access to Specialist	--	--	--
Access to Behavioral Health	--	No diff	No diff

-- = Beneficiaries using Std/Extra have LOWER scores than beneficiaries using OHI
+ = Beneficiaries using Std/Extra have HIGHER scores than beneficiaries using OHI
no diff = Beneficiaries using Std/Extra have STATISTICALLY SIMILAR scores to beneficiaries using OHI

Summary of 2008/2009 Results: Comparing Std/Extra to Non-Std Averages (Continued)

Care experiences	2008/2009 Std/Extra vs. Non-Std		
	All	PSA	Non-PSA
Access:			
Getting care quickly	No diff	No diff	No diff
Timely appointments	No diff	No diff	+
Urgent care	No diff	No diff	No diff
Less travel time (specialist)	No diff	No diff	+
Preventive Services			
Getting Pap smear	No diff	No diff	No diff
Getting mammography	--	--	No diff
Cholesterol check	--	--	--
Smoking cessation counseling	No diff	No diff	No diff

-- = Beneficiaries using Std/Extra have LOWER scores than beneficiaries using OHI
+ = Beneficiaries using St d/Extra have HIGHER scores than beneficiaries using OHI
no diff. = Beneficiaries using Std/Extra have STATISTICALLY SIMILAR scores to beneficiaries using OHI

Active and Reserve Standard Eligible Population Proximity to Prime Service Areas and Military Treatment Facilities

Proximity of non-enrolled or TRS Active and Reserve residences to PSAs is similar (82% vs. 78% respectively); but proximity to MTF- Service Areas may be less for both and especially Reserves (60% vs. 51%).

Beneficiary Group	Population Totals (FY09)	%in Prime Service Areas	%in MTF Service Areas
TOTAL ACTIVE COMPONENT (AD family, Retired and Family <65	1,725,636	81.8%	60.3%
TOTAL RESERVE COMPONENT	279,848	78.0%	51.1%
GRAND TOTAL	2,005,484	81.3%	59.0%

Conclusions

- Beneficiaries in non-Prime Service, compared to their counterparts in Prime Service Areas:
  - Report greater access to, and experience of/satisfaction with, TRICARE Standard and Extra

- S/E beneficiaries, compared to MHS beneficiaries who rely on other health insurance:
  - Rate their overall satisfaction with the Plan, Care, personal provider and specialist provider similarly.
  - Rate the timeliness of access to care similarly (e.g. getting care quickly, getting urgent care, timely appointments and travel time.
  - Rate their access to care lower (e.g. getting needed care, and access to personal doctors, specialists, or behavioral health care.

Provider Survey

- The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008, Section 711 (Public Law (P.L.) 110-181) requires:
  - Two surveys: one of providers and one of TRICARE beneficiaries.

This briefing

    - Survey civilian providers (physicians and non-physician mental health providers) to assess acceptance of TRICARE Standard/Extra patients, in at least 20 geographic areas where TRICARE Prime is offered and 20 where it is not offered.
    - Survey beneficiaries in same locations as surveyed providers, especially where Selected Reserve members reside, to identify extent of problems of access or satisfaction.
      - Beneficiary sample includes beneficiaries eligible for Standard or Extra: active duty family members, mobilized reservist family members, retirees and TRICARE Reserve Select (TRS) enrollees.
  - Solicit input from beneficiaries (TRICARE Beneficiary Panel) and providers (Representative of the American Medical Association) to identify locations where access is considered a problem.
    - Government Accountability Office (GAO) review of survey process, procedures and analysis, and action taken by the Department to ensure ready access to the Standard/Extra benefit.

Summary of Provider Survey Findings (2 OF 4 Years: 2008 – 2009)

- About 8 of 10 providers overall (physician and behavioral health) are aware of the TRICARE program, while 6 of 10 accept new TRICARE Standard patients if they accept any new patients:
  - *Almost 9 of 10 physicians are aware* of the TRICARE program in general, which is similar to benchmark survey findings (*87%* each, respectively, 3 percentage points higher than in 2008).
  - *About 7 of 10 physicians accept new TRICARE Standard patients* if accepting any new patients at all, which remains lower than the benchmark survey, but improved (69% vs. 81%, 3 percent higher than in 2008).
  - However, psychiatrists and non-physician behavioral health providers report lower levels of awareness, acceptance of new TRICARE Standard and Medicare patients, than non-psychiatrist-physicians.
  - All providers, physicians only, and non-physician behavioral health providers, each report accepting *any* new patients (of any insurer) at rates higher than in the benchmark survey (95% vs. 92%)

Summary of 2008-2009 Provider Survey Findings (Continued)

- PSA vs. non-PSA results:
  - Providers in Non-PSAs reported higher average rates of awareness of the TRICARE program, and acceptance of new TRICARE standard patients (of those accepting any new patients as well as those accepting new Medicare patients) than in PSA locations:
    - Similar results by PCP, specialists or psychiatrists , and non-physician behavioral health providers except therapists.

- On average, PSAs and non-PSAs accept new TRICARE Standard patients for all claims about equally.

- Dominance of non-PSA pattern holds for acceptance of Medicare patients and TRICARE as it relates to Medicare:
  - Non-PSA providers are more likely to accept new Medicare patients (69%) than PSA providers (65%);
  - Non-PSA providers report higher rates of accepting new TRICARE Standard patients if they accept new Medicare

Summary of Provider Survey Findings (Continued)

- But averages mask variation by PSA and Non-PSA location:
  - Awareness is:
    - highest among PSAs in the Savannah, Valdosta, Albany GA. area (almost 100%) while the 2008 surveyed Manhattan-Poughkeepsie area remains the lowest (about 50%).
    - highest among non-PSAs in Alaska excluding the Anchorage area (97%), and lowest in the East Long Island/NJ Morristown area (67%).
    - Note that the Anchorage HSA was also very high in reported awareness (99%) and "middle of the pack" for accepting new TRICARE standard if accepting any new (71%).
  - Acceptance of new TRICARE Standard/Extra patients of those accepting any new patients is:
    - Highest among PSAs in Great Falls, MT (94%) and lowest in the Sacramento, CA area (35%%).
    - Highest among non-PSAs in the 2008 surveyed Bismarck-Grand Forks-Minot ND area (84%) and lowest in the East Long Island/NJ Morristown area (49%).
    - Among HSAs, lowest in Dallas/Ft. Worth, TX area (52%)

2008-2009 Combined Results: Physician & Mental Health Providers Compared to 2005-2007 Survey Benchmark

- **Physician-reported awareness of the TRICARE program in general is similar to benchmark survey findings (87% each, respectively,**
- **But lower for accepting new TRICARE**

	Benchmark(2005-2007 MD Results	711 Physicians	711 non-Phys BH	All 711 Providers		All-PSA	All-Non PSA
Aware	**87**	87.3 No difference from bench	62.7 * Less than benchmark	78.0 * Less than benchmark		76.6** * Less than benchmark	84.9
Accept any New Patients	92	**95.5 *Greater than benchmark**	**95.4 *Greater than benchmark**	**95.4 *Greater than benchmark**		**95.7** * Greater than benchmark**	94.1** * Greater than benchmark
Accept New TRICARE Std	**76**	65.9 *Less than benchmark	36.0 *Less than benchmark	54.6 *Less than benchmark		52.7 ** * Less than benchmark	**64.3** *Less than benchmark**
Accept New TRICARE all Claims (if any)	**91**	81.3 *Less than benchmark	58.7 *Less than benchmark	75.7 *Less than benchmark		75.6 ** * Less than benchmark	76 *Less than benchmark
Accept New TRICARE if Accept any New	**81**	69.0 *Less than benchmark	37.8 *Less than benchmark	57.3 *Less than benchmark		55.1 ** * Less than benchmark	**68.4** *Less than benchmark**
Accept New Medicare	**88**	86.0 *Less than benchmark	35.4 *Less than benchmark	65.8 *Less than benchmark		65.1 ** * Less than benchmark	**69.4** *Less than benchmark**
Accept New TRICARE if New Medicare	**87**	72.8 *Less than benchmark	52.3 *Less than benchmark	68.5 *Less than benchmark		66.4 ** * Less than benchmark	**78.4** *Less than benchmark**

Note: Green highlighted areas reflect higher rates than comparison group (i.e. PSA vs non-PSA or PSA vs non-PSA PCP). * differs from benchmark; ** p≤0.05: differs from PSA, p≤0.05

2008-2009 Combined Results: Comparison of all Physician Specialty Rates to Benchmark

	All Providers	MD				Benchmark: 2005-2007 MD Results			
		All non-Psychiatrist Physicians	PCP	Spec	Psych-iatrists	All Physicians	PCP	Spec	Psych-iatrists
% Aware	78.0	88.5	89.1	88.0	68.9	87.0	88.0	87.0	71.0
% Accept ANY new Pts	95.4	**95.9***	**93.3***	**98.3***	**89.6***	92.0	89.0	95.0	82.0
% Accept Any New TRICARE	54.6	67.5*	64.1*	70.7	40.6	**76.0**	**72.0**	79.0	48.0
Accept New TRICARE - all claims (if any TRICARE)	75.7	82.3*	83.1	81.6*	57.6*	**91.0**	90.0	**91.0**	**79.0**
Accept New TRICARE if Accept ANY	57.3	70.5*	68.8*	71.9*	45.6*	**81.0**	**80.0**	**83.0**	**57.0**
Accept New Medicare	65.8	88.4	82.1	93.1	52.2	88.0	81.0	92.0	65.0
Accept New TRICARE if Accept New Medicare	68.5	73.4*	72.2*	74.1*	60.9*	**87.0**	**85.0**	**88.0**	**72.0**

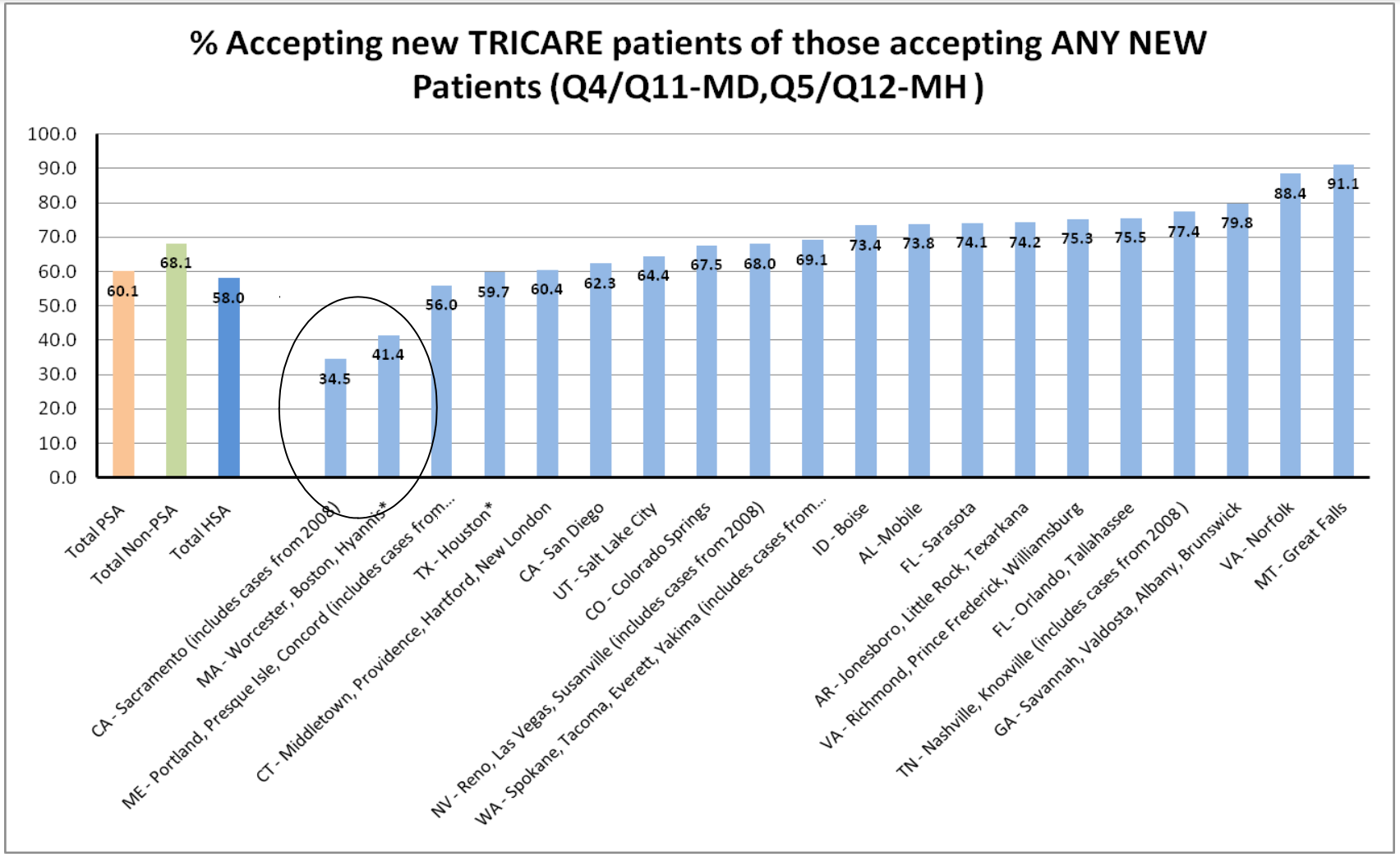
Note: Green highlighted areas reflect higher rates than comparison group (i.e. current vs benchmark).
* - differs from benchmark, $p<0.05$; differs from PSA, $p<0.05$

2008-2009 Results: Comparison of All Providers By PSA and non-PSA with High and Low locations

	Bench-Mark (2005-2007 MD Results	All-PSA	All-Non-PSA		PSA High	PSA Low	Non PSA High	Non PSA Low
Aware	87	76.6	84.9		99.6 Savannah, Valdosta, Albany	49.8 NYC area (Manhattan-Poughkeepsie)	97.2 AK	66.6 NY – East Long Island/NJ Morristown
Accept any New Patients	92	**95.7** *	94.1		98.5 Central Texas (Amarillo, Abilene, Wichita Falls, Del Rio, Harlington, San Antonio	86.9 Hawaii	99.0 AK	87.1 WA – Olympia, Seattle, Yakima
Accept New TRICARE Standard	76	52.7 *	64.3		87.5 Newport News, Suffolk	30.9 Sacramento	83.7 ND - Bismarck, Grand Forks, Minot	46.3 NY – East Long Island/NJ Morristown
Accept New TRICARE all Claims (if any)	91	75.6	76.0		87.7 Newport News, Suffolk	60.2 Spokane, Tacoma	94.0 MN – St Cloud, Duluth	52.9 WI – La Crosse
Accept New TRICARE if Accept any New	81	55.2 *	**68.4**		91.1 Great Falls	34.5 Sacramento	86.1 ND - Bismarck, Grand Forks, Minot	48.8 NY – East Long Island/NJ Morristown
Accept New Medicare	88	65.1 *	69		79.9 Pittsburgh	36.6 Sacramento	86.6 PA – Johnstown, Pittsburgh	46.3 NM
Accept New TRICARE if New Medicare	87	66.4	**78.4**		94.3 Great Falls	44.6 NYC Area	91.7 KS - Wichita	57.1 NY – East Long Island/NJ Morristown

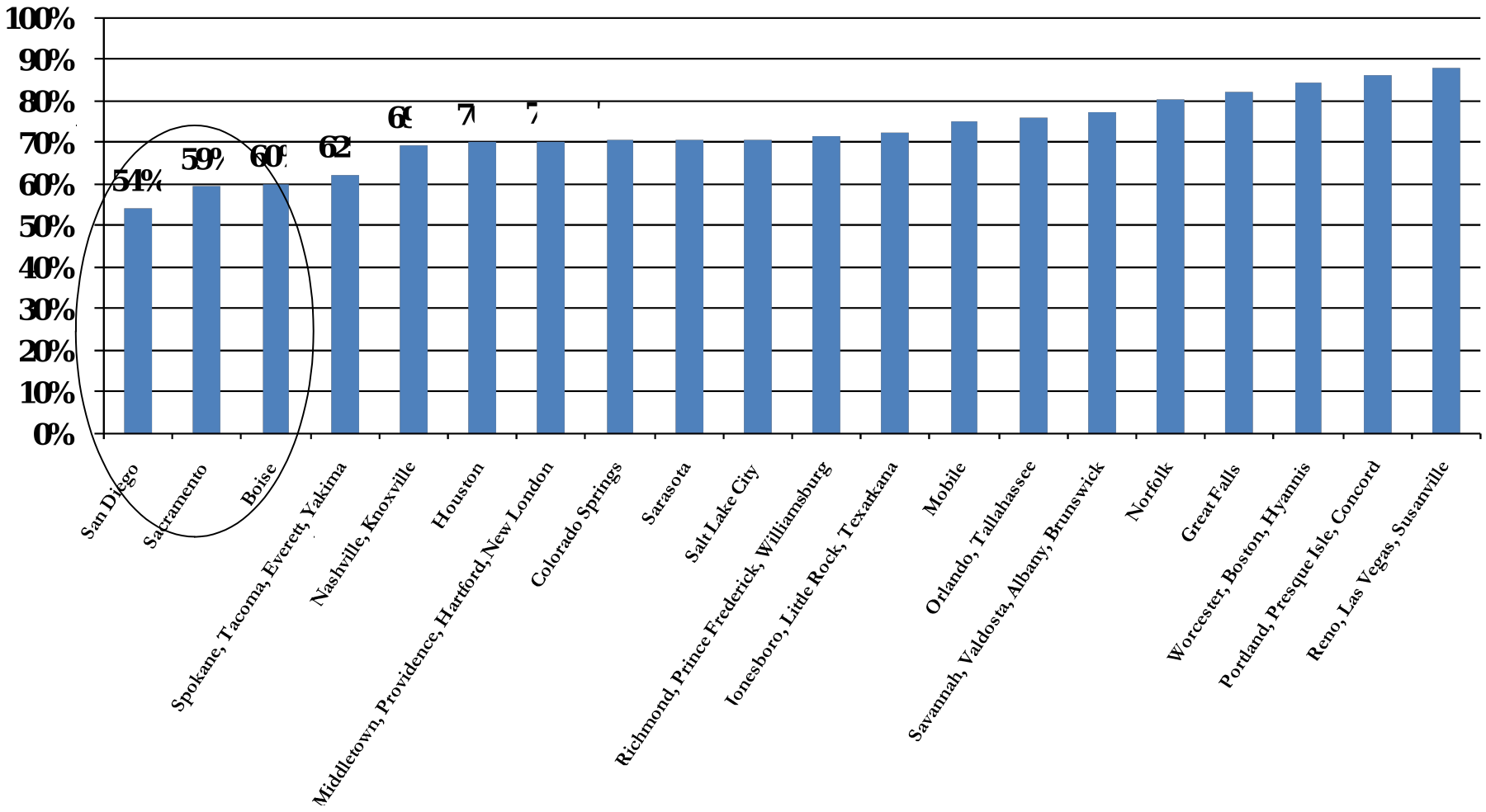
Note: Green highlighted areas reflect higher rates than comparison group (i.e. PSA vs.non-PSA or PSA-PCP vs. non-PSA PCP), * difference significant, $p<0.05$;

Variation Within PSAs: Provider Survey: Percent of PSA Providers Accepting New TRICARE Standard Patients if Accepting Any New



- Great Falls, MT had the highest percentage of PSA providers accepting new TRICARE Standard patients and Sacramento, CA the lowest percentage

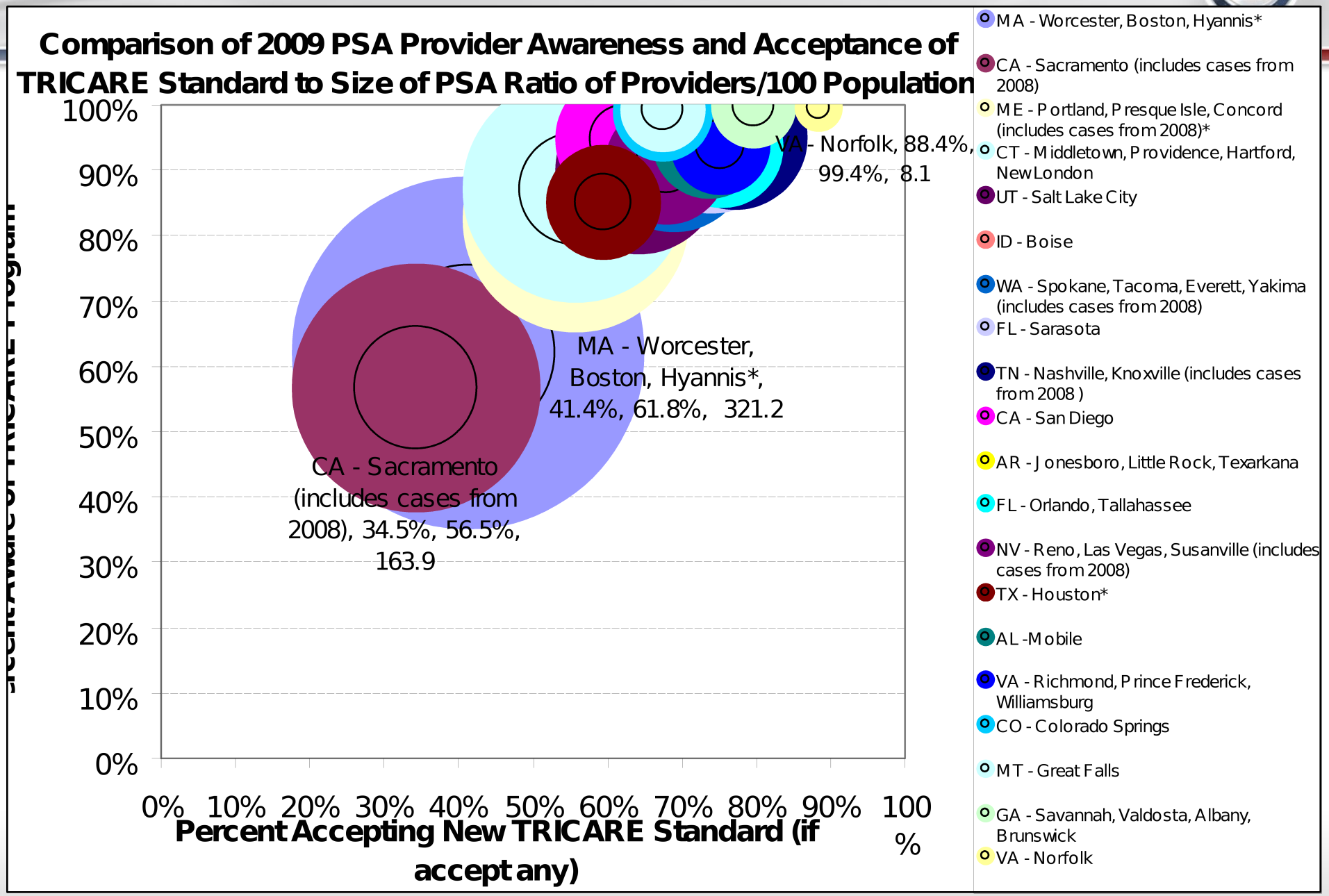
Beneficiary Ratings of Care in PSAs (2009 Sites): Getting to See a Specialist



Combined Beneficiary and Provider Survey Results: Opportunities in 2009 PSAs

PSA/ Non-PSA	Region		% Aware of TRICARE	NEW TRICARE patients of those Accepting ANY	Personal Doctor Access	Specialist Doctor Access	Getting Needed Care	Getting Care Quickly
PSA	Sacramento	CA	57%	34%	67%	59%	66%	82%
PSA	Worcester, Boston, Hyannis	MA	62%	41%	77%	84%	80%	87%
PSA	Portland, Presque Isle, Concord	ME	82%	56%	70%	86%	82%	87%
PSA	Houston	TX	85%	60%	57%	70%	81%	77%
PSA	Middletown, Providence, Hartford, New London	CT	87%	60%	54%	70%	82%	84%
PSA	San Diego	CA	95%	62%	74%	54%	76%	82%
PSA	Salt Lake City	UT	90%	64%	77%	71%	82%	86%
PSA	Colorado Springs	CO	99%	68%	63%	71%	80%	88%
PSA	Reno, Las Vegas, Susanville	NV	91%	68%	74%	88%	81%	81%
PSA	Spokane, Tacoma, Everett, Yakima	WA	92%	69%	48%	62%	82%	86%
PSA	Boise	ID	95%	73%	55%	60%	74%	84%
PSA	Mobile	AL	94%	74%	65%	75%	84%	77%
PSA	Sarasota	FL	95%	74%	56%	71%	83%	79%
PSA	Jonesboro, Little Rock, Texarkana	AR	96%	74%	71%	72%	83%	83%
PSA	Richmond, Prince Frederick, Williamsburg	VA	94%	75%	63%	71%	83%	84%
PSA	Orlando, Tallahassee	FL	94%	75%	64%	76%	86%	77%
PSA	Nashville, Knoxville	TN	95%	77%	71%	69%	80%	80%
PSA	Savannah, Valdosta, Albany, Brunswick	GA	100%	80%	70%	77%	89%	83%
PSA	Norfolk	VA	99%	88%	72%	80%	89%	77%
PSA	Great Falls	MT	99%	91%	73%	82%	90%	91%

Lowest 2nd Lowest 3rd Lowest


Comparison of 2009 PSA Provider Awareness and Acceptance of TRICARE Standard to Size of PSA Ratio of Providers/100 Population
Percent Aware of TRICARE Program
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
VA - Norfolk, 88.4%, 99.4%, 8.1
MA - Worcester, Boston, Hyannis*, 41.4%, 61.8%, 321.2
CA - Sacramento (includes cases from 2008), 34.5%, 56.5%, 163.9
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Percent Accepting New TRICARE Standard (if accept any)
MA - Worcester, Boston, Hyannis*
CA - Sacramento (includes cases from 2008)
ME - Portland, Presque Isle, Concord (includes cases from 2008)*
CT - Middletown, Providence, Hartford, New London
UT - Salt Lake City
ID - Boise
WA - Spokane, Tacoma, Everett, Yakima (includes cases from 2008)
FL - Sarasota
TN - Nashville, Knoxville (includes cases from 2008)
CA - San Diego
AR - Jonesboro, Little Rock, Texarkana
FL - Orlando, Tallahassee
NV - Reno, Las Vegas, Susanville (includes cases from 2008)
TX - Houston*
AL -Mobile
VA - Richmond, Prince Frederick, Williamsburg
CO - Colorado Springs
MT - Great Falls
GA - Savannah, Valdosta, Albany, Brunswick
VA - Norfolk

Combined Beneficiary and Provider Survey Results: Opportunities in 2009 non-PSAs

PSA/ Non-PSA	Region		%Aware of TRICARE	%Accepting NEW TRICARE patients of those Accepting ANY NEW patients	Personal Doctor Access	Specialist Doctor Access	Getting Needed Care	Getting Care Quickly
Non-PSA	East Long Island, Albany, NJ - Morristown	NY	67%	49%	55%	71%	83%	84%
Non-PSA	Anchorage	AK	76%	55%	54%	51%	74%	80%
Non-PSA	Marquette, Muskegon, Petoskey, Traverse City, Saginaw	MI	88%	67%	64%	84%	91%	85%
Non-PSA	Milwaukee	WI	87%	67%	62%	80%	89%	93%
Non-PSA	Salt Lake City	UT	84%	67%	65%	71%	83%	84%
Non-PSA	Kalamazoo, St. Joseph	MI	86%	68%	57%	64%	82%	81%
Non-PSA	Omaha	NE	92%	72%	83%	86%	90%	89%
Non-PSA	Columbus	OH	87%	73%	59%	79%	89%	90%
Non-PSA	Fargo, Moorhead	ND	91%	73%	76%	87%	90%	88%
Non-PSA	Bend, Eugene, Medford	OR	97%	73%	62%	80%	85%	85%
Non-PSA	Washington, MD - Salisbury	DC	92%	74%	77%	83%	90%	83%
Non-PSA	Bloomington, Peoria, Urbana	IL	88%	75%	61%	81%	89%	88%
Non-PSA	Wichita, OK - Tulsa	KS (OK)	88%	75%	79%	85%	87%	89%
Non-PSA	Erie	PA	93%	77%	83%	82%	91%	88%
Non-PSA	Charleston	WV	90%	78%	74%	77%	89%	81%
Non-PSA	Lynchburg, Norfolk, Richmond	VA	96%	78%	78%	81%	91%	82%
Non-PSA	Albuquerque	NM	92%	79%	64%	74%	85%	80%
Non-PSA	Appleton, Neenah, Green Bay	WI	91%	79%	68%	85%	92%	91%
Non-PSA	Rochester, St. Paul	MN	92%	80%	79%	88%	94%	90%
Non-PSA	Durham, Raleigh, Greenville, Wilmington	NC	95%	81%	67%	75%	89%	82%

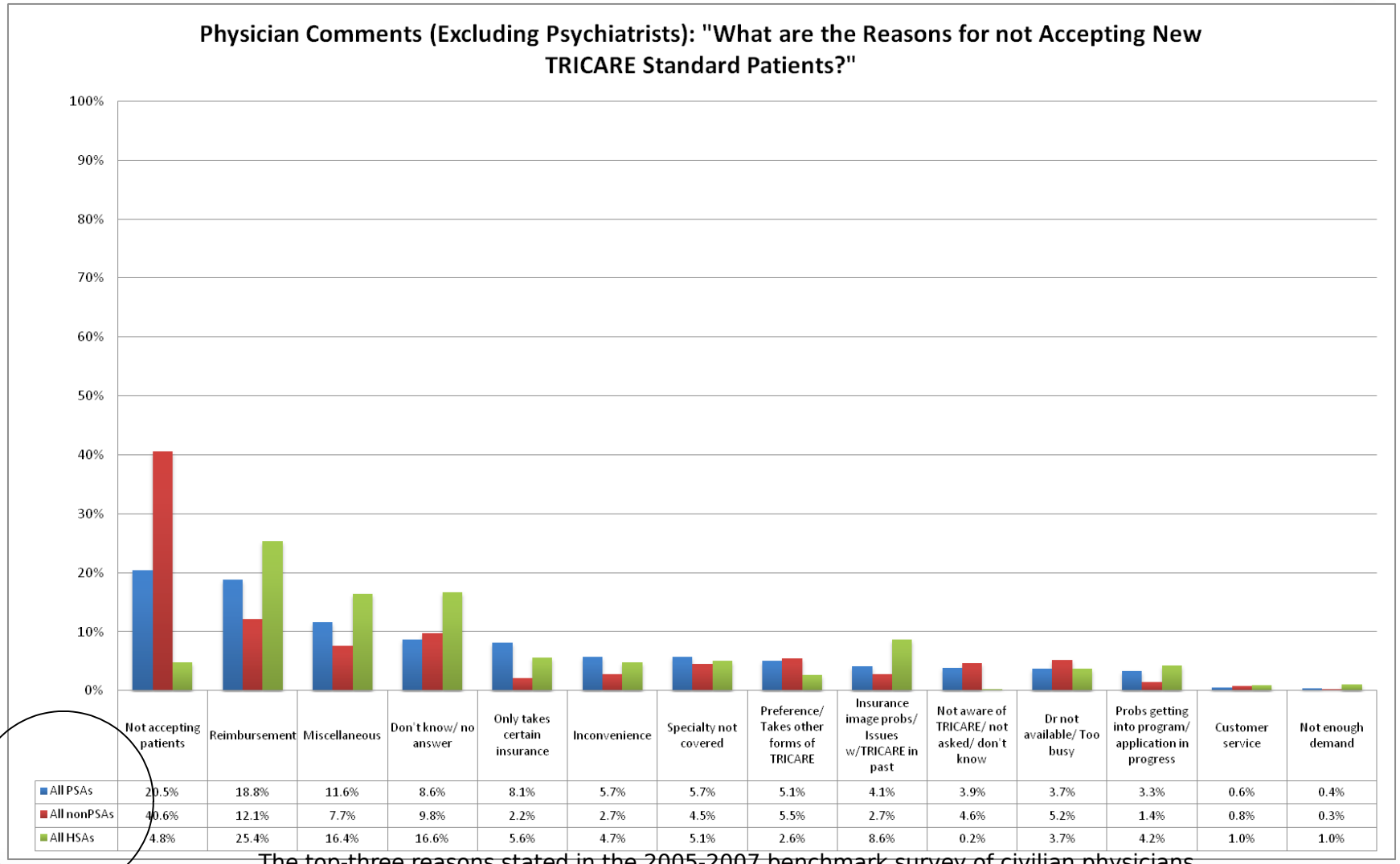
Lowest 2nd Lowest 3rd Lowest

Combined Beneficiary and Provider Survey Results: Opportunities in 2009 HSAs

PSA/ Non-PSA	Region		% Aware of TRICARE	% Accepting NEW TRICARE patients of those Accepting ANY NEW patients	Personal Doctor Access	Specialist Doctor Access	Getting Needed Care	Getting Care Quickly
HSA	Dallas/Ft. Worth	TX	87%	51.75%	44%	56%	65%	78%
HSA	Houston/Galveston	TX	83%	55.32%	52%	64%	75%	69%
HSA	Lebanon/Portsmouth/Man	NH	79%	55.66%	74%	82%	86%	86%
HSA	RoanokeVA	VA	93%	66.84%	76%	87%	88%	81%
HSA	AnchorageAK	AK	99%	70.60%	52%	60%	64%	82%
HSA	Greenville/Spartanburg	SC	94%	71.90%	63%	83%	85%	85%
HSA	Columbia/Sumter	SC	97%	76.68%	61%	82%	84%	77%
HSA	Ioshua TreeCA	CA	100%	84.73%	46%	56%	65%	69%
HSA	KilleenTX	TX	100%	86.62%	34%	76%	71%	86%

Lowest 2nd Lowest 3rd Lowest

Reasons Cited by the 3 of 10 Physicians Who do Not Accept New TRICARE STANDARD Patients (Sorted by PSA reporting)



	Not accepting patients	Reimbursement	Miscellaneous	Don't know/ no answer	Only takes certain insurance	Inconvenience	Specialty not covered	Preference/ Takes other forms of TRICARE	Insurance image probs/ Issues w/TRICARE in past	Not aware of TRICARE/ not asked/ don't know	Dr not available/ Too busy	Probs getting into program/ application in progress	Customer service	Not enough demand
All PSAs	20.5%	18.8%	11.6%	8.6%	8.1%	5.7%	5.7%	5.1%	4.1%	3.9%	3.7%	3.3%	0.6%	0.4%
All nonPSAs	40.6%	12.1%	7.7%	9.8%	2.2%	2.7%	4.5%	5.5%	2.7%	4.6%	5.2%	1.4%	0.8%	0.3%
All HSAs	4.8%	25.4%	16.4%	16.6%	5.6%	4.7%	5.1%	2.6%	8.6%	0.2%	3.7%	4.2%	1.0%	1.0%

The top-three reasons stated in the 2005-2007 benchmark survey of civilian physicians were:

1. Reimbursement (ranging from 24-29% depending on the year)
2. Not aaccepting new patients (12-14%)

Conclusions- Provider Survey Results

- **PSA vs. non-PSA**: The average rates of provider awareness of the TRICARE program and acceptance of new TRICARE Standard patients is higher in non-PSA locations than in PSA locations.
- **Comparison to benchmark**: Combined provider results after two years of this four-year study are below the 2005-2007 national physician-only survey results used as benchmark
  - Comparing physicians only, results are comparable to the benchmark physicians with respect to awareness but lower for accepting new TRICARE Standard patients and new Medicare patients.
  - Specialists generally reflect higher acceptance rates than primary care physicians.
- Psychiatrists and non-physician behavioral health providers consistently have lower rates than either specialty or primary care physicians, but are similar in reporting greater awareness and acceptance in non-PSAs than in PSAs.

Questions?

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2011 Military Health System Conference

Examination of the Access to Care Metrics and Beneficiary Response to Outpatient Satisfaction Surveys

The Quadruple Aim: Working Together, Achieving Success

LTC Lorraine Babeu

25 Jan 2011

Background

- Ensuring that its 9.6 million beneficiaries have appropriate access to the health care system is one the performance metrics monitored by the Department of Defense's health plan, TRICARE.
- Access to Care (ATC) standards are defined by the 32 Code of Federal Regulation (CFR) 199.17 which stipulates that active duty and TRICARE Prime enrollees have priority in scheduling appointments; the CFR also defines these standards by appointment type.
- In 2000, the Government Accounting Office (GAO) released a report (GAO/T-HEHS-00-138) which indicated that both active duty and TRICARE Prime beneficiaries were not receiving priority when scheduling appointments, and subsequently not meeting the defined TRICARE access to appointment standards

Background

- An Integrated Project Team (IPT) was organized, including a sub-team tasked with tracking access to care at military treatment facilities (MTFs). The sub-team developed a metric composed of three categories of measurement: effectiveness, efficiency and satisfaction.

- A standard appointment system and referral process were developed to address efficiency, and satisfaction was to be monitored by modifications to existing satisfaction surveys

Research Questions

Is there a relationship between survey respondents indication of getting care when needed and meeting the access to care standard?

Access to Care (ATC) Standards 32 Code of Federal Regulations (CFR) 199.17

Appointment Type	Standard
Initial Specialty Care	28 – Days
Wellness or Health Promotion	28 – Days
Future Request	28 – Days
Routine Care	7 – Days
Acute Care	24 Hours

Electronic Code of Federal Regulations (http://ecfr.gpoaccess.gov)
HA Policy Letter 02-018 (15 JAN 97)

Data Sources

TRICARE Outpatient Satisfaction Survey (TROSS)

- **Purpose:** To assess the ambulatory care experiences in the direct and purchase system.
- **Mode:** Mail (web and IVR response options) and Phone (20 questions only)
  - Survey is fielded monthly for both Direct Care and Purchased Care
- **Annual Sample Size:** ~ 512,000 (mail survey); ~ 15,000 (phone survey)

TRICARE Operation Center's Composite Health Care System (CHCS) Data

- Fully integrated medical information system for U.S. Department of Defense health care facilities world-wide.
- Automates inpatient and outpatient medical information in: patient administration, patient appointment and scheduling, radiology, pharmacy, laboratory, nursing, clinical services management, order entry/results reporting, and management reporting.

Methods

- The study population was comprised of Prime Enrollee TROSS respondents who had appointments in January thru March 2010 that were captured in the CHCS appointing system.
- TROSS and CHCS data samples were matched and then merged by unique patient identifier and appointment date.
- Access to care standards computations were conducted by the TRICARE Operations Center (TOC).
- The data was cleaned, recoded, and weighted.
- Independent and dependent variables were identified for inclusion in analytical model.
- Multinomial logit models were developed
  - **Q3a** - I am able to see my provider when needed
    - Response is 5 point scale, positive response (strongly agree, agree)
    - For the analysis used three levels of response: Agree, Neutral, Disagree

Getting Needed Care vs Meeting Standard

Q3a - Received care from provider as soon as needed		ATC Standard Met		
		Yes	No	
Agree	Frequency	902,735	190,106	1,092,841
	Percent	*82.6%*	*17.4%*	
Neutral	Frequency	205,039	37,959	242,998
	Percent	*84.4%*	*15.6%*	
Disagree	Frequency	232,134	38,682	270,816
	Percent	*85.7%*	*14.3%*	
		1,339,908	**266,747**	

Variables

Demographic Variables

- Race/Ethnicity
- Patient Age
- Beneficiary Category
- Gender
- Marital Status
- Appointment Type
- ATC Standard
- Days to appointment *

Identified TROSS Questions

- **Q3a:** I am able to see my provider when needed**
- **Q6:** In the last 12 months, when you made an appointment through the phone how would you rate the ease of making this appointment?**
- **Q16:** In the last 12 months, how often did you see this provider within 15 minutes of your appointment?**
- **Q18:** In the last 12 months, how often did this provider listen carefully to you?**
- **Q23:** In the last 12 months, how often did this provider spend enough time with you?
- **Q28:** In the past 12 months, how often were the clerks and receptionists as helpful as you thought they should be?**
- **Q32:** Using any number from 0-10, what number would you use to rate your health care?**

*Calculated using “Date Appointment was made” and “Date of Appointment” from CHCS Data **Used top 2-box for categorical TROSS questions Satisfied represented a response of 8, 9, or 10, when respondent was asked to rate on a scale of 0-10

Results

- The results ***did not*** reflect a strong relationship between the ATC standard and positive beneficiary response to the survey question getting care when needed.
  - Regression models indicated that those meeting the ATC standard were ***less*** likely to agree that they saw their provider as soon as they felt was needed, holding all else constant.

Predicators: Positive response to question about getting care when needed

Rank	
1	Ease when making an appointment through the phone (3 levels: Excellent, Good, Poor)
2	In the last 12 months, the provider listened carefully (3 levels: Always, Sometimes, Never)
3	In the last 12 months the clerks and receptionists were as helpful as they should be (3 levels: Always, Sometimes, Never)
4	In the last 12 months, saw the provider within 15 minutes of the scheduled appointment time (3 levels: Always, Sometimes, Never)
5	Beneficiary Category: Retirees and dependents aged 65 years and above

Summary

- The administrative recording of the ATC metric is largely invisible to beneficiaries and does not appear to affect their perception of getting care when needed.
- Further analysis is required to learn more about the factors that most impact the beneficiary's perception of access.

Questions?

If you have any further questions, please contact:

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Definition for CHCS in Classification

Appointment Type	Definition for CHCS in Classification
Routine	Patients who require an office visit with their PCM or mental health provider for a new healthcare problem that is not considered urgent. Routine mental healthcare is defined as an initial request for a new mental health condition or exacerbation of a previously diagnosed condition for which intervention is required but is not urgent.
Initial Specialty Care Appointment (SPEC)	Designed for the initial consult or referral appointment to a specialist or an initial self referral for specialty care by a patient to a specialist. The appointing information system will assign the ATC Standard and Category that matches the referral priority entered by the requesting provider. A SPEC appointment may be booked for a consult or referral with any priority; it's used only for specialty clinics and primary care clinics with specialty care.
Acute appointment (ACUT)	Designed for scheduling appointments for beneficiaries who have a need for non-emergent, urgent care that require treatment within 24 consecutive hours.
Wellness or Health Promotion Appointment (WELL)	Designated for patients who require preventive, health maintenance care (e.g., physical examinations, periodic examinations, check-ups, screenings, etc.).
Established Patient Follow-up with Designated Time Allotment (EST)	Designated for patients who request a follow-up appointment with the PCM that is not for acute health care, routine primary care, initial PCM appointments, wellness care, or to have a procedure performed. The EST is also designed for a patient who requests a follow-up appointment with a specialist for other than initial specialty care, acute health care, wellness, or to have a procedure performed.